Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BONE & JOINT CLINIC OF HOUSTON

Respondent Name
FREESTONE INSURANCE CO

MFDR Tracking Number
M4-14-3282-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received a denial stating the time limit had expired. We submitted this back to the insurance carrier several times, with proof of timely filing and each time Segwick did not pay for the services rendered. I have attached a total of 4 EOB'S from Segwick, along with the HCFA, Proof of Timely filing and documentation of the visit on the date of service in question."

Amount in Dispute: $1,032.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs raise the issue of timely filing…The health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 2, 2013	CPT Code 99203-25 Office Visit	$220.00	$166.49
	CPT Code 20610-LT Arthrocentesis of Knee Joint	$232.00	$92.94
	HCPCS Code J0702 Injection of Betamethsone Acetate 3mg and Sodium Phosphate 3mg	$10.00	$6.77
	CPT Code 99080-73 Work Status Report	$15.00	$15.00
	HCPCS Code L1820-LT Knee Orthotic	$185.00	$157.01
	HCPCS Code L2425 (X2) Addition to Knee Joint	$370.00	$336.34
TOTAL		$1,032.00	$774.55

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §133.307, effective June 1, 2012, sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
5. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
6. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
7. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 937-Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
   - OA-The amount adjusted is due to bundling or unbundling of services.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247-A payment or denial has already been recommended for this service.

Issues

1. Did the requestor support that disputed bill was submitted timely?
2. Is the requestor due reimbursement for CPT ode 99203-25 and 20610?
3. Is the requestor due reimbursement for HCPCS code L1820 and L2425?
4. Is the requestor due reimbursement for HCPCS code J0702?
5. Is the requestor due reimbursement for CPT code 99080-73?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed office visit and services based upon reason code "29."

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.'

   28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The requestor submitted a report with USPS One Code Confirmation ID: 0024090000301425546440512 that indicates bill was delivered to Segwick CMS on October 19, 2013. The Division finds that the requestor has supported position that bill was submitted in accordance with Texas Labor Code §408.027(a). As a result, reimbursement is recommended.

2. 28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other

payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

On the disputed date of service, the requestor billed CPT codes 99203-25, 20610-LT, J0702, 99080-73, L1820-LT and L2425.

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.0791

Review of Box 32 on the CMS-1500 the services were rendered in The Woodlands, Texas. Per Medicare the provider is reimbursed using the locality of "Rest of Texas".

Code	Medicare Participating Amount	MAR	Total Paid	Total Due
99203	$102.43	$166.49	$0.00	$166.49
20610	$43.83	$92.94	$0.00	$92.94

3. 28 Texas Administrative Code §134.203 (d)(1) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

Code	DMEPOS Participating Amount	MAR	Total Paid	Total Due
L1820	$125.61	$157.01	$0.00	$157.01
L2425	$134.54	$168.17 X2 = $336.34	$0.00	$336.34

4. HCPCS code J0702 does not have a relative value unit or payment listed in DMEPOS; therefore, reimbursement for these services are set out in 28 Texas Administrative Code §134.203 (f).

   28 Texas Administrative Code §134.203(d) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS."

The Texas Medicaid rate for J0702 is $5.42; therefore, the MAR is $5.42 X 125% = $6.77. The respondent paid $0.00. As a result, reimbursement of $6.77 is recommended.

5. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

   28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

   28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:
   (1) after the initial examination of the employee, regardless of the employee's work status."

   The requestor submitted a copy of the work status report to support billed service; therefore, reimbursement of $15.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $774.55.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $774.55 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	07/25/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.